 Commentary: Is there a common background behind growing inequalities in mortality in Western European countries?

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Advancing social equity in health has been a main objective in the WHO's Health for All programmes as well as in numerous documents outlining national health policies in countries all over the world since the early 1980s. Nevertheless, existing evidence suggests that—contrary to the political aim—health disparities have actually increased, particularly if we consider the gravest indicator of ill health, mortality.1–4

In this issue of the International Journal of Epidemiology, Mackenbach et al. show that, in all the six European countries included in their analysis, relative mortality disparities in the middle-aged population have continued to widen markedly at least up to the mid-1990s.5 Also, in absolute terms, the inequities have slightly increased in most cases. In each country, i.e. the four largest Nordic countries, England & Wales, as well as Italy (Turin), this general finding applies to both women and men whether socioeconomic position is measured according to level of education or occupational class. The differences between these countries in the steepness of the socioeconomic mortality gradient appear to have remained fairly stable.

The parallel findings in all the six different countries suggest that the widening of the mortality gap results from similar reasons in each of the countries included in the analysis, and possibly in other established market economy countries as well. Cause-specific analyses included in the article by Mackenbach et al. do not, however, provide obvious support for this common background assumption. In the countries analysed, as well as in other Western countries, cardiovascular diseases cause about 30–50% of all deaths in the middle-aged population. Among men in the four Nordic countries and in England & Wales, the contribution of cardiovascular diseases to the increase in socioeconomic inequities in mortality has been considerably larger than the proportion of total mortality attributable to this disease group. On the basis of the data presented in the article, we can calculate that approximately two-thirds of the increase in men's mortality differences can be attributed to cardiovascular diseases in these five North European countries. This finding suggests that explanations for the widening mortality inequalities should be sought among factors which affect the risk of dying of cardiovascular diseases but have a much weaker effect, if any, on the other causes of death.

Results concerning women in all the six countries—as well as Italian men—show also that other factors than those causing cardiovascular deaths play an important role. In women in the five North European countries, the role of cardiovascular diseases is not accentuated as this disease group contributes to the widening of the socioeconomic mortality gap with approximately the same share that it has on the overall mortality level. Furthermore, in Italy (Turin) the steepening of the socioeconomic mortality gradient results totally from causes of death other than cardiovascular diseases among both women and men.

Mackenbach et al. do not present a comprehensive decomposition of the increase in mortality differences by cause of death. However, they provide evidence suggesting that causes of death associated with smoking and excessive use of alcohol have contributed to the widening mortality disparities at least among women. A more complete decomposition of the increase in inequity by cause of death would be most useful to pinpoint the areas needing special emphasis. For example, Martikainen et al. have shown that—in addition to cardiovascular diseases—alcohol-related causes, accidents, and suicide have had a marked role in the widening of mortality differentials in Finland, whereas social inequalities in some other causes of death have remained stable.6

It is obvious that different causes of death—and a number of aetiological factors behind these causes of death—contribute to the recent increase in social inequalities in mortality in Western countries. Furthermore, the importance of the various reasons appears to vary between populations and genders. What are the scientific and political implications of these findings?

The similarity of the time trends in socioeconomic inequalities in overall mortality across countries can hardly result from mere coincidence. Therefore, it seems worthwhile pursuing a common denominator for the parallel increase in mortality inequities in different countries, despite the fact that the contribution of different causes of death varies between populations. Increasing income inequality has been offered as the common reason that may cause growing mortality disparities7 but this explanation is not valid in the Nordic countries.8 In addition to material wealth, other wide-ranging resources of health should be considered as potential general reasons for growing inequalities in mortality. Examples of possible causes include access to good quality health services, social networks, control over one's life, and motivation to promote one's health, arising for example from being considered as a valuable member of the community. Something in the recent economic and cultural development in Western countries seems to have benefited particularly the well-off classes in terms of survival and its prerequisites. The mechanisms through which this social development has affected mortality inequalities appear to vary according to the

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cause of death and risk factor pattern and other population-specific factors.

From a health policy point of view, two broad lines of action can be identified in trying to reduce social inequalities in mortality. It is obvious that national health policies have to aim at developing means to tackle the factors which have been established as causes of growing inequalities in mortality in the population, such as unequal access to best available health services and social differences in tobacco or alcohol use or other risk factors. In addition, as many national and international health policy documents emphasize, it is necessary to reduce social inequalities in the general material and cultural resources of health and wellbeing.9

References